

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/22/2014
NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS		STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for an Investigation of Complaint #IN00146419.</p> <p>Complaint #IN00146419 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: April 22, 2014</p> <p>Facility number: 000104 Provider number: 155197 AIM number: 100266590</p> <p>Survey team: Shelly Miller- Vice, RN</p> <p>Census bed type: SNF: 16 SNF/NF: 57 Residential: 113 Total: 186</p> <p>Census payor type: Medicare: 14 Medicaid: 55 Other: 117 Total: 186</p> <p>Sample: 6</p> <p>Sanctuary at St. Pauls was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2. in regard to the Investigation of Complaint IN00146419.</p> <p>Quality Review 04/23/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE